

U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)



Issue Date: 12 April 2006

In the Matter of
KENNETH R. MEADE
Claimant

Case Number: 2005 BLA 5050

v.

PARAMONT COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Joseph Wolfe, Attorney
For the Claimant

Mr. Timothy Gresham, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Kenneth Meade for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural History

On May 19, 2003, Mr. Meade filed a claim for black lung disability benefits under the Act (DX 2).¹ On October 27, 2003, the District Director issued a preliminary analysis stating that claimant would be entitled to benefits based on the medical evidence in the record (DX 19). In response, Paramount Coal Company submitted additional medical evidence (DX 21, 22 and 24). On July 6, 2004, the District Director issued a Proposed Decision and Order awarding benefits (DX 27). On July 9, 2004, employer appealed and requested a hearing before an Administrative Law Judge (DX 29). Pursuant to a Notice of Hearing, dated December 3, 2004, I conducted a hearing in Abingdon, Virginia on March 17, 2005 (ALJ I). Mr. Meade, Mr. Gresham and Mr. Wolfe attended the hearing.

Evidentiary Discussion

Both at the hearing and during the adjudication of this claim, several evidentiary issues arose which I now address.

Digital Chest X-Ray

In his evaluation of a radiographic image taken October 5, 2004, Dr. Scatarige stated that the image was digital and thus not subject to classification under the NIOSH system (EX 2). Although Dr. Robinette used the NIOSH form in evaluating the same image (CX 1), no physician has directly refuted Dr. Scatarige's comments about the digital nature of the study. As a result, I will treat the October 5, 2004 image as a digital chest x-ray.

Recently, the Benefits Review Board ("BRB" and "Board") determined that digital chest x-rays shall be considered as "other medical evidence" under 20 C.F.R. § 718.107, rather than 20 C.F.R. § 718.202 (a) (1), which permits the use of traditional chest x-ray film to establish the presence of pneumoconiosis. *Webber v. Peabody Coal Co*, 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc). According to the Board, in considering the digital image under 20 C.F.R. § 718.107, I must determine whether that evidence is medically acceptable and relevant to entitlement. In terms of acceptability, I note that while Dr. Scatarige declined to use the NIOSH form, he nevertheless found the image sufficient to render an interpretation. Likewise, Dr. Robinette did not hesitate to interpret the digital x-ray (CX 1). Thus, based on the physicians' apparent acceptance of the digital image and since an assessment of whether pneumoconiosis is present in Mr. Meade's lungs is a relevant issue, CX 1 and EX 2 are admissible and will be evaluated under 20 C.F.R. § 718.107.²

¹ The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

² CX 1 also contains an radiology consult by Dr. Mullins diagnosing black lung based on his electronic review. The BRB also determined in *Webber* that only one interpretation of a study under 20 C.F.R. § 718.107 is permitted. As a result, Dr. Mullins' assessment is not admissible.

Rebuttal Chest X-Ray³

The Claimant submitted a positive interpretation by Dr. Alexander of a July 16, 2003 chest x-ray (DX 25) as rebuttal to the DOL chest x-ray interpretation of the same film by Dr. Patel, which was also positive for pneumoconiosis (DX 12). Although both physicians found the presence of pneumoconiosis, Claimant's counsel advocated for admission of Dr. Alexander's assessment because the doctors reached different conclusions about the shape of the opacities – round versus irregular. Due to this difference, counsel asserts Dr. Alexander's interpretation qualifies as a permissible rebuttal interpretation under 20 C.F.R. § 725.414 (a) (2) (ii). Understandably, Employer's counsel objected to the admission of Dr. Alexander's interpretation. Further, to the extent that Dr. Alexander's assessment was admissible, the Employer offered a contrary interpretation of the film by Dr. Scott (DX 24).

In light of the above noted BRB's directive concerning the characterization and treatment of digital x-rays, and its impact on this case, I conclude Dr. Alexander's interpretation has become admissible as a case-in-chief chest x-ray. Unfortunately, as has become routine under the new regulations, a lengthy explanation is required.

As a starting point, because Dr. Robinette's interpretation of the October 5, 2004 digital chest x-ray is now considered as other medical evidence under 20 C.F.R. § 718.107, its admissibility is governed by the evidentiary limits associated with 20 C.F.R. § 718.07, rather than the evidentiary restrictions in 20 C.F.R. § 728.414 (a) (2) (i). Recently, the BRB stated "20 C.F.R. § 718.107 is reasonably interpreted to allow for submission, as part of a party's affirmative case, of one reading or each separate test or procedure undergone by the claimant." *Webber*, slip op. at 8. Thus, under the BRB's rule, Dr. Alexander's interpretation is admissible on the Claimant's behalf under 20 C.F.R. § 718.107 as the "one" reading of that October 5, 2004 digital chest study.

Next, at the hearing, Claimant's counsel designated Dr. Robinette's interpretation as one of the Claimant's two allowable case-in-chief chest x-ray interpretations under 20 C.F.R. § 725.414 (a) (2) (i). However, since Dr. Robinette's study now comes into evidence under 20 C.F.R. § 781.107, it no longer counts as one of the two case-in-chief interpretations under 20 C.F.R. § 725.414 (a) (2) (i).

As a consequence, the Claimant has the opportunity to provide another supportive chest x-ray interpretation as part of his case-in-chief. In this case, that second interpretation is supplied by Dr. Alexander's positive interpretation of the July 16, 2003 chest x-ray. In other words, Dr. Alexander's interpretation of the July 16, 2003 chest x-ray is now admissible as a case-in-chief interpretation under 20 C.F.R. § 725.414 (a) (2) (i) and I do not need to address whether its admissible as rebuttal under 20 C.F.R. § 725.414 (a) (2) (ii).

Finally, since the BRB also recently concluded that each party may submit one rebuttal interpretation for each interpretation presented by the other party in its affirmative case, Dr.

³At the hearing, I deferred a decision on the admission of the interpretations of a July 16, 2003 chest x-ray by Dr. Alexander (DX 25) and Dr. Scott (DX 24) (TR, pages 10 to 13).

Scott's negative interpretation of the July 16, 2003 chest x-ray (DX 24) is now admissible under 20 C.F.R. § 725.414 (a) (3) (ii). *See Ward v. Consolidation Coal Co.*, 23 B.L.R. 1-___, BRB No. 05-0595 BLA (March 28, 2006), slip op. at 5.

Medical Record Evidence

In DX 24, the Employer presented over a hundred pages of medical reports, tests, and radiographic interpretations under the provision of 20 C.F.R. § 718.414 (a) (4) which permits the admission of medical records related to pulmonary and respiratory treatment. Upon review, I find most of the evidence related to Mr. Meade's pulmonary care, including radiographic interpretations from Saint Mary's Hospital are admissible. However, several chest x-ray studies, most of them captioned in part "Public Health Service" and "Medical Examination Program," do not appear to be associated with any pulmonary treatment. Instead, these radiographic interpretations appear to be related to non-treatment pulmonary examinations. Consequently, absent any indication of a treatment-related purpose, I exclude from the evidence and will not consider the following chest x-ray interpretations: January 4, 1974 (Dr. Navani); December 19, 1979 (Dr. Silberger); September 11, 1992 (Dr. DePonte); September 11, 1992 (Dr. Ellingson); September 18, 2000 (Dr. Navani); and, September 18, 2000 (Dr. Sider).

Additionally, Dr. McIlwain's orthopedic treatment notes do not fall within the admission criteria of 20 C.F.R. § 718.414 (a) (4).

Pulmonary Evaluation Reports

In his pulmonary evaluation report (EX 3), Dr. Fino expressed agreement with Dr. Wheeler's admissible negative chest x-ray interpretation of the February 21, 2004 film. In his deposition (EX 7), Dr. Fino indicated that his expressed agreement was not intended to be a formal chest x-ray interpretation. While Dr. Fino's agreement has not been offered as a chest x-ray interpretation, it might nevertheless be considered an interpretation that exceeds the regulatory evidence restrictions. In that case, an issue arises since Dr. Fino's report would include inadmissible evidence.

In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc) when confronted with a medical opinion that contained evidence not admitted into the formal record, the Benefits Review Board indicated that an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or, d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. Since Dr. Fino simply expressed his agreement with the admissible chest x-ray interpretation, I will not consider that comment in my adjudication, effectively redacting Dr. Fino's expression of agreement. Additionally, since Dr. Fino had an admissible negative chest x-ray interpretation by Dr. Wheeler as a partial basis for his conclusions, the redaction does not adversely affect the probative value of his opinion.

In a similar manner, Dr. Hippensteel also expressed his agreement with Dr. Wheeler's negative interpretation of the January 21, 2004 chest x-ray (DX 24). In regards to Dr.

Hippensteel's opinion about the film, I take the same remedial measure of redaction and conclude the redaction does not adversely affect the probative value of his opinion.

As part of his assessments, Dr. Fino also reviewed Mr. Meade's medical record and radiographic interpretations in DX 24. However, as previously discussed, several items in DX 24 are not admissible, including six non-treatment negative chest x-ray interpretations. Rather than exclude Dr. Fino's report based on his review of that inadmissible evidence, I have considered whether it impacts the probative value of his opinion. In that regard, although Dr. Fino emphasized that the preponderance of the chest x-ray evidence was negative, his belief is not inconsistent with my following determination that the preponderance of the chest x-ray evidence is indeed negative for the presence of pneumoconiosis. Accordingly, I find Dr. Fino's consideration of the inadmissible chest x-ray interpretations does not adversely affect the probative value of his opinion.

Additional Comments

At the hearing, I provided Claimant's counsel an opportunity to obtain a re-reading of the February 10, 2005 chest x-ray (TR, page 17). In a post-hearing telephone conference call, Claimant's counsel indicated that a re-reading would not be submitted.

I also left the record open for the post-hearing deposition of Dr. Fino's deposition (TR, page 27). On April 12, 2005, I received a transcript of Dr. Fino's April 4, 2005 deposition, which I now admit as EX 7.

Summary

In light of the above comments, my decision in this case is based on the hearing testimony and the following exhibits admitted into evidence: DX 1 to DX 37, CX 1, and EX 1 to EX 7 (with exceptions noted).

ISSUES

1. Whether Mr. Meade has pneumoconiosis.
2. If Mr. Meade has pneumoconiosis, whether his disease arose out of coal mine employment.
3. Whether Mr. Meade's total disability is due to coal workers' pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Meade had post-1969 coal mine employment; b) the length of Mr. Meade's coal mine employment was at least 22 years; c) Paramount Coal Company is the responsible operator; d) Mr. Meade suffers from a

totally disabling pulmonary impairment, and e) Mrs. Constance Meade is a dependent for the purposes of augmenting any benefits that may be payable under the Act. (TR, pages 7, 8, 28, 29 and 30).

Preliminary Findings

Born on May 27, 1948, Mr. Meade married Ms. Constance Hensley Meade on March 25, 1967 (DX 2 and DX 8). Mr. Meade started coal mining in 1972 and accumulated no less than 22 years of coal mine employment by the time of retirement in 2002. In the course of claimant's career as a coal miner, Mr. Meade performed a variety of tasks ranging from general inside laborer to shuttle car operator, before retiring as a superintendent (DX 10). His final job as superintendent required Mr. Meade to walk, crawl, and engage in some heavy labor including moving of equipment and rock dust (DX 10)

Since Mr. Meade did not testify at the formal hearing, I must rely on the varying accounts of his cigarette smoking habit in the number medical reports and examinations. After considering all of the medical evidence, I conclude that at the very least, Mr. Meade has a 25 pack year⁴ history of cigarette smoking.

Issue #1 – Presence of Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.⁵ The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as “any chronic lung disease arising out of coal mine employment.”⁶ The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201 (b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),⁷ and medical opinion (§ 718.202 (a)(4)). Since the record does not contain any evidence the claimant has complicated pneumoconiosis, and Mr.

⁴A pack-year equals the consumption of one pack of cigarettes per day for one year.

⁵20 C.F.R. § 718.201 (a).

⁶20 C.F.R. § 718.201 (a) (1) and (2) (emphasis added).

⁷If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Meade filed this claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, to demonstrate pneumoconiosis, Mr. Meade will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. In addition, since Mr. Meade labored as a coal miner in West Virginia, under the guidance of *Compton*,⁸ I must consider the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

Chest X-Ray Interpretations

Date of x-ray	Exhibit	Physician	Interpretation
03/12/1996	DX 24	Dr. DePonte, B, BCR	Clear lungs (negative for pneumoconiosis) ⁹
04/08/1996	DX 24	Dr. Gentry	Clear lungs (negative for pneumoconiosis).
08/02/1996	DX 24	Dr. Doyle	The lungs are somewhat hyperinflated, but generally clear (negative for pneumoconiosis).
02/07/1997	DX 24	Dr. DePonte, B, BCR	Clear lungs (negative for pneumoconiosis).
04/15/2002	DX 24	Dr. Westerfield, B, BCR	Negative for pneumoconiosis or asbestosis.
07/16/2003	DX 12	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion 1/0, type s/t opacities. Mild COPD (chronic obstructive pulmonary disease).
(same)	DX 22	Dr. Hayes, B, BCR	Negative for pneumoconiosis.
(same)	DX 25	Dr. Alexander, B, BCR	Positive for pneumoconiosis, profusion 1/0, type p opacities.
(same)	DX 24	Dr. Scott, B, BCR	Negative for pneumoconiosis.
12/22/2003	DX 23	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion 1/0, type s/t opacities; mild COPD present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis; possible emphysema present.
01/24/2004	DX 24	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
2/10/2005	EX 3a	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Hyperinflation consistent with emphysema present.

Of the nine chest x-rays, there is no dispute regarding seven of the films. Based on unopposed interpretations, the following chest x-rays are negative for pneumoconiosis: March 12, 1996, April 8, 1996, August 2, 1996, February 7, 1997, April 15, 2002, January 24, 2004, and February 10, 2005.

⁸See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

⁹Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. See *Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

The physicians who examined the remaining two chest x-rays reached contrary conclusions. In the July 16, 2003 chest x-ray, Dr. Patel and Dr. Alexander observed pneumoconiosis; whereas, Dr. Hayes and Dr. Scott did not. Since all four physicians have the same credentials as board certified radiologists and B readers, their professional standoff renders the July 16, 2003 film inconclusive for the presence of pneumoconiosis. Concerning the December 22, 2003 radiographic image, Dr. Patel and Dr. Wheeler had the same disagreement. According to Dr. Patel, the chest x-ray is positive for pneumoconiosis. When Dr. Wheeler reviewed the same film, he determined it was negative. As a result, the December 22, 2003 chest x-ray is also inconclusive for the presence of pneumoconiosis.

In summary, seven of the nine chest x-rays in the record are negative for pneumoconiosis and the other two films are inconclusive. Consequently, the preponderance of the chest x-ray evidence is negative and Mr. Meade is unable to establish the presence of pneumoconiosis in his lungs by radiographic evidence under 20 C.F.R. § 718.202 (a) (1).

Other Medical Evidence and Medical Opinion

Although Mr. Meade is unable to prove the presence of pneumoconiosis by chest x-ray evidence, he may still prove that he has black lung disease 20 C.F.R. § 718.202 (a) (4) through medical opinion and other medical evidence.

As stated in the earlier evidentiary discussion, digital chest x-rays are properly considered as “other medical records” rather than as a normal chest x-ray film because of present regulations and NIOSH criteria. Consequently, I will first consider the interpretations by Dr. Robinette and Dr. Scatarige of the October 5, 2004 digital chest x-ray, under 20 C.F.R. § 718.107. Next, to facilitate an understanding of the various other medical opinions concerning Mr. Meade’s pulmonary condition, I will summarize the other objective medical test results. Finally, I will turn to the various medical evaluations.

Digital Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
10/5/2004	CX 1	Dr. Robinette, B	Positive for pneumoconiosis, profusion 1/0, type s/t opacities. Emphysema present.
(same)	EX 2	Dr. Scatarige, B, BCR	Hyperinflation consistent with emphysema, but no findings to suggest pneumoconiosis or silicosis.

Although Dr. Robinette and Dr. Scatarige are NIOSH certified B-Readers, only Dr. Scatarige is also board certified in radiology. As a result, his opinion is entitled to greater weight on the issues of whether the digital chest x-ray reveals any evidence of pneumoconiosis.¹⁰ Thus, based on the preponderance of the more probative medical assessment, I find the digital chest x-

¹⁰See *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader.)

ray of October 5, 2004 is negative for the presence of pneumoconiosis. Further, I note that to the extent Dr. Scatarige's credentials do not enhance the probative value of his opinion, the professional standoff between Dr. Robinette and Dr. Scatarige would render the October 5, 2004 digital chest x-ray at best inconclusive.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre¹¹ post¹²	FVC pre post	MVV pre post	% FEV¹ / FVC pre post	Qualified¹³ pre post	Comments
DX 24	08/18/1999 Byers	51 71.0"	2.21 2.63	4.17 4.59		53 57	Yes ¹⁴ No	
DX 11	07/16/2003 Dr. Rasmussen	55 70.0"	1.59 1.88	3.61 4.35	56 74	44.0 43.2	Yes ¹⁵ Yes	Acceptable per Dr. Michos (DX 9).
DX 23	12/22/2003 Dr. Rasmussen	55 70"	1.68 2.21	4.10 4.95		40.9 44.6	Yes No	Severe, significantly reversible obstruction
DX 24	01/21/2004 Dr. Hippensteel	55 70.0"	1.43 1.91	3.13 4.01	49	46 48	Yes Yes	Severe airflow obstruction.
CX 1	10/05/2004/ Dr. Robinette	56 69"	1.59 1.81	3.01 3.95		52.8 45.8	Yes ¹⁶ Yes	Reversible, moderate obstruction.
EX 3	02/10/2005 Dr. Fino	56 70.0"	1.65 2.07	4.03 4.74		40.9 43.7	Yes ¹⁷ Yes	

¹¹Test result before administration of a bronchodilator.

¹²Test result following administration of a bronchodilator.

¹³Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

¹⁴The qualifying FEV1 number is 2.27 for age 51 and 71"; the corresponding qualifying FVC and MVV values are 2.86 and 91, respectively.

¹⁵The qualifying FEV1 number is 2.11 for age 55 and 70"; the corresponding qualifying FVC and MVV values are 2.67 and 84, respectively.

¹⁶The qualifying FEV1 number is 2.03 for age 56 and 69"; the corresponding qualifying FVC and MVV values are 2.58 and 81, respectively.

¹⁷The qualifying FEV1 number is 2.09 for age 56 and 70"; the corresponding qualifying FVC and MVV values are 2.65 and 84, respectively.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified ¹⁸	Comments
DX 24	04/19/1996 Dr. Byers	38.0	69.0	No ¹⁹	(During hospitalization.)
DX 24	09/24/2001 Dr. Shamiyeh	38.1	71.6	No.	
DX 11	07/16/2003 Dr. Rasmussen	39.0 40.0	71.0 72.0	No ²⁰ No ²¹	Normal.
DX 23	12/22/2003 Dr. Rasmussen	35.0 40.0	80.0 74.0	No ²² No	
DX 24	01/21/2004 Dr. Hippensteel	41.3 38.8	77.9 74.8	No No	Normal gas exchange with exercise.
CX 1	10/5/2004 Dr. Robinette	41.0	84.0	No	.
EX 3	02/10/2005 Dr. Fino	43.5 45.4	64.7 77.9	No No	

Dr. John G. Byers, Jr.
(DX 24)

On March 30, 1996, Dr. Byers, board certified in pulmonary and internal medicine, examined Mr. Meade at a regional hospital after he suffered deep vein thrombosis (“DVT”) and dyspnea in the previous two weeks. The physician performed a complete physical examination which revealed reasonably clear breath sounds at rest but harsh expiratory wheezing with deep breathing along with a congested cough consistent with asthmatic bronchitis. A pulmonary angiogram was negative for a pulmonary embolus. In response to a question posed by the claimant, the physician noted in the record that “On being asked, I did inform him that his symptoms at this time are not consistent with black lung, which should give a restrictive ventilatory process.” In a discharge summary, dated March 31, 1996, Dr. Byers diagnosed exacerbation of dyspnea with atypical chest pain, asthmatic bronchitis and probable chronic obstructive lung disease or chronic bronchitis caused by cigarette smoking.

Once again on April 8, 1996, Mr. Meade presented to Dr. Byers with right leg and right chest pain and chronic anxiety about another possible pulmonary embolism. On physical examination, the physician found clear breath sounds, and admitted the Claimant for monitoring

¹⁸To qualify for Federal Black Lung Disability benefits at a coal miner’s given pCO² level, the value of the coal miner’s pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

¹⁹For the pCO² of 38, the qualifying pO² is 62, or less.

²⁰For the pCO² of 39, the qualifying pO² is 61, or less.

²¹For the pCO² of 40 to 49, the qualifying pO² is 60, or less.

²²For the pCO² of 35, the qualifying pO² is 65, or less.

of a possible pulmonary embolism. Upon admission, the physician diagnosed COPD with wheezing, possibly partly reversible. However, during the course of hospitalization, a clot in Mr. Meade's leg vein was discovered and he suffered severe chest pain. Mr. Meade was placed on blood thinner and pain medication. These medications significantly improved the claimant's pain around the right lung. A final examination revealed decreased breath sounds in the right chest, and chest scans showed a reduction of infiltrates in the right lower lobe.

On August 18, 1999, Dr. Byers, conducted a pulmonary examination of Mr. Meade after a referral from the Claimant's primary physician due to his concern about a recurrent pulmonary emboli. On physical examination, the physician noted some wheezing. A pulmonary function study revealed a partially reversible obstructive pulmonary impairment, which the physician attributed to asthmatic bronchitis. A lung scan was indeterminate; however, based on the "history of his symptom complex," Dr. Byers believed Mr. Meade may have suffered an asthmatic bronchitic attack. Dr. Byers discussed asthma and asthmatic bronchitis with Mr. Meade. Dr. Byers prescribed inhalers and advised Mr. Meade to stop smoking cigarettes.

Dr. Souhail G. Shamiyeh
(DX 24)

On 1 September 1999, Mr. Meade presented to Dr. Shamiyeh (the claimant's personal physician) at St Mary's Hospital due to sudden onset of shortness of breath after suffering from a cold for nearly a week. The physician recorded the claimant's past medical history and present symptoms, including shortness of breath, hypoxia, congestion and a hard cough. Mr. Meade was a coal mine superintendent and smoked cigarettes at the rate of half a pack a day. A physical examination revealed bilateral wheezes and decreased breath sounds. After admission to the hospital for two days and oxygen therapy, the claimant's condition returned to baseline. In the discharge summary, Dr. Shamiyeh diagnosed acute asthmatic bronchitis, COPD and a history of DVT and pulmonary emboli.

Dr. Michael B. Baron
(DX 24)

On 10 May 2000 and again on 16 May 2000, Mr. Meade visited Dr. Baron for a second opinion concerning pulmonary issues. The physician noted his medical history, 30 years of coal mine employment, and continued smoking habit of three cigarettes a day. Upon physical examination, Dr. Baron heard decreased breath sounds with slight wheezing on forced expiration. A pulmonary function study indicated mild pulmonary obstruction with "significant improvement." Dr. Baron diagnosed COPD and asthma and prescribed inhalers.

Dr. Donald L. Rasmussen
(DX 10 and DX 23)

On 16 July 2003, Dr. Rasmussen, board certified in internal medicine, conducted a complete pulmonary examination of Mr. Meade. The physician recorded the claimant's personal, employment and medical histories including 30 years of coal mining and a continuing cigarette smoking habit of one pack per day that totaled 29 pack years. The Claimant reported

some wheezing and dyspnea. A physical examination revealed reduced breath sounds. The chest x-ray was positive for pneumoconiosis; the pulmonary function study revealed a severe, partially reversible obstructive pulmonary impairment. The arterial blood gas study was normal. Based on Mr. Meade's history of coal mine employment and the positive chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. The physician also indicated that Mr. Meade had COPD, an airflow obstruction, attributable to both coal mine dust and cigarette smoke. He explained, "both cause similar lung tissue damage sharing some cellular and biochemical mechanisms." Mr. Meade was totally disabled due to his pulmonary impairment.

On 22 December 2003, Dr. Rasmussen conducted another pulmonary examination. The physician recorded Mr. Meade's personal, employment and medical history. According to Dr. Rasmussen, the claimant's present pulmonary complaints included long term and worsening dyspnea, chronic cough, and some wheezing. The claimant reported a nearly 30 pack year history of cigarette smoking, with a reduction from a pack a day to a pack a week. A physical examination revealed reduced breath sounds. In reference to chest x-rays, Dr. Rasmussen noted Dr. Patel's positive chest x-ray interpretation. The pulmonary function study revealed a severe, significantly reversible obstructive pulmonary impairment with a moderate loss of lung function, which would prevent Mr. Meade from returning to coal mine employment. Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on a significant exposure to coal dust and a positive chest x-ray interpretation. According to the physician, the claimant's risk factors include probable asthma, cigarette smoking and coal dust exposure. Both cigarette smoke and coal dust caused Mr. Meade's lung tissue damage.

Dr. Kirk E. Hippensteel
(DX 24 and EX 6)

On 21 January 2004, Dr. Hippensteel, board certified in internal medicine and pulmonary disease, conducted a complete pulmonary examination. The physician recorded Mr. Meade's personal and employment history of 29 years of coal mine employment, including the physical requirements of the claimant's last employment. Mr. Meade had also been a pack a day cigarette smoker since he was 23 years old. In the physical examination, Dr. Hippensteel noted no significant rales or wheezes after the administration of a bronchodilator. A pulmonary function study revealed severe airflow obstruction that markedly improved after administration of a bronchodilator. An arterial blood gas study showed normal gas exchange at rest and after exercise. The claimant's carboxyhemoglobin level was consistent with a current smoking habit. The chest x-ray was negative. Based the examination, Dr. Hippensteel concluded that Mr. Meade does not suffer from pneumoconiosis. Mr. Meade's pulmonary impairment was caused by a long cigarette smoking history. The "dramatic improvement" in lung function after use of bronchodilator therapy also indicated possible asthma.

Dr. Hippensteel also conducted a review of the medical record since 1996 and concluded Mr. Meade suffers from an obstructive pulmonary impairment with significant reversibility consistent with asthmatic bronchitis and a long cigarette smoking history. Mr. Meade's problems were inconsistent with pneumoconiosis which causes a fixed pulmonary impairment. Dr. Hippensteel disagreed with Dr. Rasmussen's diagnosis of pneumoconiosis first noting Dr. Rasmussen identified the possibility of asthma only in his December 2003 report and did not

mention it in the July 2003 evaluation. Dr. Hippensteel also noted that the irregular marking in Dr. Patel's chest x-ray findings were "atypical" for pneumoconiosis. Instead, Dr. Patel's radiographic finding was typical of obese persons, active smokers, and asthmatics with bronchitis.

In a March 3, 2005 deposition, Dr. Hippensteel provided a detailed explanation concerning his diagnosis of Mr. Meade's pulmonary condition based on three aspects of the pulmonary and arterial blood gas test results. First, Mr. Meade's pulmonary function test showed significant reversibility in his pulmonary obstruction. After use of a bronchodilator, Mr. Meade's various pulmonary function measurements improved 15 to 33%. This significant reversibility is not consistent with an impairment due to coal dust exposure. Second, the lung volumes showed some air trapping without any restriction. Although a coal dust related impairment can produce that symptom, the result is also consistent with asthma. Third, Mr. Meade's diffusion capacity was consistently normal. If pulmonary fibrosis or emphysema were present, Dr. Hippensteel would expect to see abnormal diffusion results. Although Dr. Fino observed a decrease in diffusion, he conducted his test just four months after Dr. Rasmussen's normal diffusion test. As a result, Dr. Hippensteel believes Dr. Fino's result is transitory and not indicative of Mr. Meade's actual diffusion capacity. Consequently, in light of these findings, Dr. Hippensteel opined that Mr. Meade has not suffered permanent lung tissue damage attributable to pneumoconiosis or coal dust exposure.

In summary, Dr. Hippensteel concluded Mr. Meade does not have pneumoconiosis or a coal dust-related pulmonary disease. He emphasized that most physicians did not see pneumoconiosis in the chest x-ray films. No evidence of a restrictive lung impairment due to lung tissue destruction was present. The reversible obstruction was consistent with asthma and cigarette smoking. In non-coal miner patients who smoke cigarettes, Dr. Hippensteel observed the same symptoms as Mr. Meade presented. Dr. Byers, who has treated Mr. Meade for his pulmonary problems, had diagnosed, and provided treatment for, asthmatic bronchitis. Mr. Meade is totally disabled due to asthmatic bronchitis and a long, and continuing, history of cigarette smoking. Although Mr. Meade spent a substantial portion of his 29 years of coal mine employment at the mine's face, Dr. Hippensteel does not attribute any part of Mr. Meade's pulmonary impairment to that coal dust exposure.

Dr. Emory H. Robinette
(CX 1)

On 5 October 2004, Dr. Robinette, board certified in pulmonary disease and internal medicine,²³ conducted a complete pulmonary examination of the Claimant. In a personal and medical history review, Dr. Robinette recorded the claimant's employment history as a nearly 30 year coal miner. His medical history included a pulmonary emboli. Mr. Meade also had at least a 25 pack year cigarette smoking history. The claimant's present complaints included dyspnea, chronic cough and episodic wheezing.

²³As I advised the parties at the hearing (TR, pages 6 and 7), I take judicial notice of Dr. Robinette's board certification and have attached the certification documentation.

A physical examination revealed diminished breath sounds with wheezes and rhonchi on forced expiration. The digital chest x-ray was positive for pneumoconiosis, with pulmonary fibrosis and emphysema. The pulmonary function study demonstrated moderate obstructive lung disease with response to bronchodilator. An arterial blood gas study revealed normal resting levels. The carboxyhemoglobin was elevated. After considering claimant's personal and employment history along with the medical evidence from this pulmonary examination, Dr. Robinette diagnosed simple coal worker's pneumoconiosis and moderate obstructive lung disease, "moderate in severity with response to bronchodilator therapy." Mr. Meade's moderate pulmonary defect was "in part due to his coal mining employment." At the same time, Dr. Robinette acknowledged "the patient does have some contribution of his respiratory dysfunction from his past nicotine consumption." Mr. Meade was totally disabled from coal mine employment.

Dr. Gregory J. Fino
(EX 3 and EX 7)

On 10 February 2005, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted a pulmonary examination. The physician recorded the claimant's personal, employment (30 years of coal mining), medical and smoking (26 pack years) histories. The claimant reported dyspnea with significant physical activity, but denied any history of asthma or bronchiectasis. A physical examination revealed decreased breath sounds bilaterally. The physician noted a negative chest x-ray interpretation of a 10 February 2005 film by Dr. Wheeler. A pulmonary function study revealed a moderately severe obstructive impairment which improved after the administration of a bronchodilator. An arterial blood gas study revealed mild hypoxemia with no evidence of impairment in oxygen transfer.

Dr. Fino also reviewed Mr. Meade's medical record and numerous pulmonary evaluations, including examinations by Dr. Rasmussen, Dr. Robinette, and Dr. Hippensteel. Based on his pulmonary examination and record review, Dr. Fino diagnosed chronic reversible pulmonary impairment consistent with asthmatic bronchitis and/or cigarette smoking along with chronic pulmonary obstruction without reversibility. Mr. Meade's oxygen transfer was not impaired. The majority of negative chest x-ray interpretations and pulmonary function studies establish the fixed and reversible pulmonary obstructions are related to cigarette smoking. In addition, the physician noted that although Mr. Meade had a reduced diffusing capacity in the present examination, the diffusing capacities in an examination performed by Dr. Robinette four months earlier were normal, a variability the physician attributes to cigarette smoking. Such diffusion variability is inconsistent with "anatomic destruction" due to emphysema or pulmonary fibrosis.

In an April 4, 2005 deposition, Dr. Fino discussed the rationale for his conclusion that Mr. Meade does not have pneumoconiosis. Initially, he observed that Mr. Meade's prescribed medications include treatment for a reversible airways obstruction, such as asthmatic bronchitis. Next, Dr. Fino observed that while Mr. Meade's resting blood gas study showed mild hypoxemia, the exercise blood gas test was normal. Obesity, which is applicable in Mr. Meade's case, can cause resting hypoxemia and shortness of breath; however, upon exercise, the oxygen levels return to normal. Additionally, in the pulmonary function test administered by Dr. Fino,

Mr. Meade's pulmonary functions improved 18 to 25% after using a bronchodilator. In the lung volume test, Mr. Meade had an over-inflation condition associated with a pulmonary obstruction. Further, up until Dr. Fino's examination, Mr. Meade's diffusion tests, which measure the lungs ability to get oxygen out of the air and place it in the blood stream, were normal. Either lung tissue damage or active inhalation of carbon monoxide will produce an abnormal diffusion test result. When Dr. Fino tested diffusion, the result was decreased. Since Dr. Fino believes that neither emphysema nor pulmonary fibrosis could have rapidly developed since the prior normal test, the physician opined the decreased diffusion result was due to Mr. Meade's active cigarette smoking.

In Dr. Fino's opinion, Mr. Meade does not have coal workers' pneumoconiosis or any chronic lung disease due to coal dust exposure. The nature and extent of Mr. Meade's pulmonary problem is no different than the symptoms he observes in cigarette smokers who never mined coal. Mr. Meade is totally disabled due to his low FEV₁ value, rather than his arterial blood gas capacity which is normal with exercise. Mr. Meade's totally disabling pulmonary impairment is due to his cigarette smoking and not coal mine employment.

Discussion

Of the physicians to evaluate Mr. Meade's pulmonary problems, Dr. Rasmussen and Dr. Robinette diagnosed both coal workers' pneumoconiosis and chronic lung disease attributable to his long term exposure to coal dust. Dr. Byers, Dr. Shamiyeh, Dr. Baron, Dr. Hippensteel and Dr. Baron did not find or diagnose either clinical or legal pneumoconiosis. Due to this disagreement between the medical professionals, I must first determine the relative probative value of the respective opinions in terms of documentation and reasoning.

To have probative value, a medical opinion must be both documented and reasoned. As to the first probative value factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. See *Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. § 718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these probative factors in mind, I first note that as treating physicians, Dr. Byers and Dr. Shamiyeh were in a position to develop a well informed assessment of Mr. Meade's pulmonary problem. However, due to incomplete reasoning and evaluation, their opinions have diminished probative value. Clearly, neither treating physician believed Mr. Meade had coal workers' pneumoconiosis. Instead, Dr. Byers diagnosed asthma and Dr. Shamiyeh concluded Mr. Meade struggled with COPD. However, neither physician apparently considered whether Mr. Meade's exposure to coal dust may have also contributed to his pulmonary impairment. In other words, while their opinions are probative on the issue of clinical pneumoconiosis, the assessments by Dr. Byers and Dr. Shamiyeh carry little probative weight in determining whether Mr. Meade may nevertheless have legal pneumoconiosis.

Similarly, Dr. Baron's consulting opinion also falls short in probative value because he didn't address the presence of legal pneumoconiosis. Specifically, after diagnosing COPD, the physician did not address the etiology of that pulmonary obstruction.

Although well founded on two pulmonary examinations, Dr. Rasmussen's findings of clinical and legal pneumoconiosis have diminished probative value for documentation and reasoning deficiencies. As his basis for a finding of clinical pneumoconiosis, Dr. Rasmussen specified the positive chest x-ray interpretations associated with both of his examinations. However, since he only considered the positive interpretations, Dr. Rasmussen was not aware of the contrary negative findings for the same two films or that the preponderance of the radiographic evidence was negative for pneumoconiosis. Since he didn't review those negative interpretations, Dr. Rasmussen did not address how those findings might affect the certainty of his diagnosis of clinical pneumoconiosis based on positive chest x-ray interpretations. Additionally, based on my determination that the July 16, 2003 and December 22, 2003 chest x-rays are inconclusive, rather than positive, on the presence of pneumoconiosis, and that the preponderance of the radiographic evidence is negative for pneumoconiosis, Dr. Rasmussen's clinical pneumoconiosis diagnosis rests on inaccurate documentation.

In presenting a legal pneumoconiosis diagnosis represented by his conclusion that Mr. Meade's obstructive pulmonary disease was caused in part by coal dust, Dr. Rasmussen provided a reasoned explanation that both coal dust and cigarette smoke damage lung tissue to the extent they share the same symptoms. However, upon consideration of significant reversibility demonstrated by the pulmonary function tests, which co-existed with nearly normal arterial blood gas studies, Dr. Rasmussen's opinion loses probative value because he failed to address how the notable improvement in pulmonary functions upon use of bronchodilators was consistent with the permanent damage he opined coal dust had caused to Mr. Meade's lungs.

Dr. Robinette's opinion that Mr. Meade's pulmonary defect was due in part to his coal mine employment shares similar documentation and reasoning deficiencies. As a part of his evaluation, Dr. Robinette interpreted the digital chest x-ray as positive for pneumoconiosis. However, I have found the study to be negative based on Dr. Scatarige's more probative opinion. Also, since Dr. Robinette only considered the results of his pulmonary examination, he was unaware that the preponderance of the radiographic evidence was negative for pneumoconiosis. In terms of reasoning, while highlighting the reversible nature of Mr. Meade's obstructive pulmonary defect, Dr. Robinette did not discuss how that variability affected the certainty of his

conclusion that Mr. Meade's coal dust exposure had contributed to his partly reversible obstructive impairment.

In one of the best documented medical opinions, based on a pulmonary examination and extensive review of the medical evidence, including several other pulmonary evaluations, Dr. Hippensteel presented a well reasoned and probative explanation for his determination that Mr. Meade had neither clinical nor legal coal workers' pneumoconiosis. In discussing the radiographic record, Dr. Hippensteel accurately portrayed the preponderance of the chest x-ray interpretations as negative for pneumoconiosis. Likewise, Dr. Hippensteel integrated very well all aspects of the objective medical test results, including post-bronchodilator response and near normal arterial blood gas studies, to support his conclusion that Mr. Meade had not suffered permanent lung damage due to coal dust exposure.

Utilizing the same documentary approach and applying the same integrated reasoning, Dr. Fino also provided a probative determination that the preponderance of radiographic record and the objective pulmonary test results indicate the Mr. Meade does not have coal workers' pneumoconiosis, either clinically or legally.

In summary, for various documentation and reasoning deficiencies, the pneumoconiosis and obstructive pulmonary etiology conclusions of Dr. Byers, Dr. Shamiyeh, Dr. Baron, Dr. Rasmussen, and Dr. Robinette have diminished probative value. On the other hand, the assessments of Dr. Hippensteel and Dr. Fino are well documented, reasoned, and the most complete assessments which are consistent with all the medical evidence in the record. Thus, the preponderance of the more probative medical opinion establishes that Mr. Meade does not have coal workers' pneumoconiosis or an obstructive pulmonary impairment due to coal dust exposure.

Compton Analysis

Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must also consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Meade has pneumoconiosis. Since standing alone neither the preponderance of the chest x-rays nor the more probative medical opinion established the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

CONCLUSION

Upon consideration of the entire record, I find the preponderance of the radiographic evidence is negative for pneumoconiosis. Similarly, the preponderance of the more probative medical opinion establishes that Mr. Meade does not have either clinical or legal pneumoconiosis. Accordingly, having failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, Mr. Meade's claim for black lung disability benefits must be denied.²⁴

²⁴Since Mr. Meade has failed to establish the presence of pneumoconiosis, I need not address the other two issues in this case.

ORDER

The black lung disability benefits claim of MR. KENNETH R. MEADE is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: April 11, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

Dr. Emory H. Robinette, Jr.

Certified by the American Board of Internal Medicine in:

Internal medicine and pulmonary disease

American Board of Medical Specialties

1007 Church Street, Suite 404

Evanston, IL 60201-5913

Phone Verification: (866) ASK-ABMS

Phone: (847) 491-9091/FAX: (847) 328-3596

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